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ABSTRACT

Comprehensive health care (preventive, curative, rehabilitative, and environmental) for more than 930,000 eligible American Indians and Alaska Natives is the responsibility of the Indian Health Service (IHS). Since 1955, this agency of the U.S. Public Health Service has made notable progress in raising the health status of Indians and Alaska Natives, following policies outlined in Public Laws 93-638, 94-437, and 96-537. IHS operates 48 hospitals, 72 health centers, 12 school health centers, and more than 500 health stations and clinics which provide primary care, preventive health services, community health nursing, dental services, medical social work, environmental health services, and health education. Over 50% of the IHS staff is of native descent. IHS provides recruitment and career development activities for nurses, community health representatives and aides, technicians, dental/optometric assistants, mental health workers, and nutrition/dietetic workers. The most serious health related problems existing in high proportions among Indians and Alaska Natives are injuries, alcoholism, mental health problems, middle ear diseases, diabetes, nutritional deficiencies, and poor dental health. Other major health concerns are maternal and child health needs, unhealthy environmental conditions, and problems associated with aging. Maps and tables indicate IHS facilities, vital statistics, and services rendered. Photographs and IHS administrative office addresses are included. (NEC)

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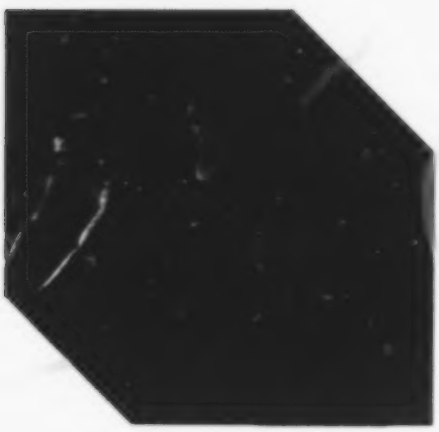
INDIAN HEALTH SERVICE

A Comprehensive Health Care Program for American Indians and Alaska Natives



[1985]

U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Indian Health Service

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Foreword

Comprehensive health care—preventive, curative, rehabilitative and environmental—for more than 930,000 eligible American Indians and Alaska Natives is the responsibility of the Indian Health Service.

Since 1955, this agency of the U.S. Public Health Service has made notable progress in raising the health status of these people to the highest possible level. In striving to carry out this goal, the dedicated staff has three main objectives:

1.) Deliver the highest quality health services possible;
2.) Assist tribes and Native corporations to develop their capacity to staff and manage health programs; and
3.) Act as the Federal advocate in health related matters.

The provision of health care is accomplished through a Federal-Tribal partnership with a common aim. We are pleased to report that the health status gap between American Indians/Alaska Natives and the rest of the Nation continues to narrow.

To maintain and increase both public and governmental support, it is essential that there be greater understanding of the health care afforded American Indians and Alaska Natives. It is to this purpose that this publication is dedicated.

Everett R. Rhoades, M.D.
Assistant Surgeon General, USPHS
Director, Indian Health Service

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Introduction

American Indians and Alaska Natives, like other citizens, benefit from public health programs intended to improve health care for all Americans. Members of federally recognized Indian tribes and Alaska Natives also are eligible for health service provided by the Indian Health Service (IHS), an organization of the U.S. Public Health Services's Health Resources and Services Administration. The Federal Government's responsibility for more than 930,000 Indians and Alaska Natives has a long history, originating from treaties dating from 1784, and further established through laws enacted by Congress.

Members of 487 federally recognized Indian tribes live primarily on Federal Indian reservations and in small rural communities. The majority of the 28 States in which these reservations are located are in the western half of the Nation. The Alaska Natives, a term embracing people of the Athabaskan, Tsimpsian, Tlingit and Haida Indian tribes and the Eskimo and Aleut peoples, live throughout Alaska, predominantly in remote, isolated villages.

The Indian and Alaska Native people have maintained much of their traditional culture. Some, especially the older people, speak little or no English. They are among the most impoverished of the U.S. population, and often live without life-serving necessities such as good nutrition and a sanitary environment. Many of the reservations and communities are located in isolated, ruggged areas where climatic conditions are often harsh. These situations, coupled with a lack of passable roads, make transportation difficult. In many areas of Alaska roads are nonexistent and ill or injured persons have to be airlifted to health facilities.

Numerous health-related problems exist in high proportions among Indians and Alaska Natives. Some of the most serious are injuries, alcoholism, mental health problems, otitis media (middle ear diseases), diabetes, nutritional deficiencies, and poor dental health. Other major health concerns are maternal and child health needs, unhealthy environmental conditions, and problems associated with aging.

Substantial progress has been made, however, in combating health problems, especially, infectious diseases. In 1955, for example, tuberculosis struck about eight of every 1,000 Indians. By 1982, the number dropped to less than one in 1,000, representing a decrease of 95 pecent in the attack rate. Reductions also have occurred in morbidity and mortality rates for other diseases. The mortality rate among infants for the 3-year period 1978-80 was down 77 percent from 1954-56, and pneumonia and influenza had been reduced by 73 percent. The mortality rate of gastrointestinal diseases has declined by 90 percent since 1954-56.

But much remains to be done before the Indian and Alaska Native people attain health parity with other Americans. In recognition of this, and the desire of the Indian and Alaska Native people to have greater control over their own destiny, Congress passed two landmark laws.

Public Law 93-638, the Indian Self-Determination and Education Assistance Act, which relates to the activities of both the Indian Health Service and the Department of the Interior's Bureau of Indian Affairs, was enacted in 1975. This legislation strengthens and enhances IHS's long-standing policy of giving Indian people maximum opportunity to become meaningfully involved in the programs serving them. Specifically, the law gives Indian tribes and Alaska Native groups the option of managing and operating health care programs in their communities. It also authorizes assistance, if needed, for any tribe or group wanting to develop or improve their capabilities to take advantage of this option.

The Indian Health Care Improvement Act, P.L. 94-437, passed in 1976, and P.L 96-537, amended in 1980, was intended to elevate the health status of Indians and Alaska Natives to a level equal to that of the general population through a 7-year program of authorized higher resource levels in the IHS budget. Appropriated resources were used to expand health services, build and renovate medical facilities, and step up the construction of safe drinking water and sanitary disposal facilities. Also established by the law were programs designed to increase the number of Indian health professionals for Indian needs, and to improve health care access for the approximately half-million Indians living in urban areas.

Physicians qualified through special training care for the newborn with complications . . .

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Mission and Organization

The IHS mission is to assure the availability of a comprehensive health care delivery system that will provide Indians and Alaska Natives opportunities for maximum involvement in defining and meeting their own health needs.

To achieve this, the Indian Health Service has three main objectives:

1. Deliver the highest quality comprehensive health care services possible, including hospital and ambulatory medical care, preventive and rehabilitative services, and community and environmental health programs, among them the construction of water and sanitation facilities.
2. Assist tribes and Native corporations to develop their ca-pacity to staff and manage health programs, and provide them with the opportunity to assume operational authority for programs, if they so choose.
3. Act as the Indians' and Alaska Natives' Federal advocate in health related matters.

In carrying out its mission, the Indian Health Service interacts with Federal and State agencies and other public and private institutions in developing ways to deliver health services, constructively use manpower, stimulate consumer participation, and apply resources.

Area/Program Administration

Headquarters of the Indian Health Service is in Rockville, Maryland, a Washington, D.C. suburb. The staff coordinates and monitors area and field activities, prepares statistical information, and provides support for policy development, budget, program formulation, planning, implementation and evaluation, operation management, community development and tribal affairs applicable to the total Indian health program.

. . . and continue to provide comprehensive health care to those who are aged.

Field Administration

IHS administratively is divided into eight area and four program offices. Each area and program office is responsible for operating the IHS program within its designated geographical area. The responsibilities of these field administrative offices include budget, operation, personnel and property management, program planning, implementation and evaluation, tribal affairs, community development, statistical information, grants and contracts management, and environmental health. Staff of area and program office health services branches such as nursing, dental, and other disciplines, work with corresponding staff at the services delivery level in IHS facilities.

Delivery of health services at the local level is the responsibility of the service unit, the administrative subdivision of the area and program office. There are 98 service units in the IHS; each covers a defined geographic area such as an Indian reservation or population concentration (Alaska, Nevada, and Oklahoma are statewide service areas without reservations).

A few service units serve a number of small reservations, and conversely some large reservations, such as that of the Navajo tribe which covers 25,516 square miles and in fiscal year 1985 has a service population of 166,000, are served by several service units. These basic health service delivery components usually contain an IHS hospital or health center where outpatient services are provided.

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Community health nurses provide a wide variety of services and work closely with other health personnel.

The emergency room nurse often is the first health care professional the patient sees.

California Program Differs

In California, health care is provided to Indians entirely through contracts with non-profit Indian and tribal organizations, and therefore, the operations of the California Program Office is somewhat different from the other IHS areas and programs. There are no IHS-operated hospitals and instead of service units, the State is divided into service areas. Nineteen rural health programs funded by the IHS provide care at 17 health centers and 10 health stations. Of the service agreements for health centers and clinics, all are P.L. 93-638 contracts and 10 are Buy Indian contracts.

All of the health programs except two receive funding from the State and therefore must comply with additional regulations. These rules include the use of third-party payors (Medicare, Medi-Cal, and private health care insurance), and the provision of services to non-Indians.

The California Program Office also administers contracts for nine urban health care centers. Alcoholism services in California and Hawaii are contracted with 14 Indian organizations.

Research and Training

The Office of Research and Development (ORD) in Tuscon, Arizona, combines the IHS's training, services research and program development activities and the health care programs for the Papago and the Pascua Yaqui tribes. ORD provides consultation and technical assistance to IHS and to tribal and Alaska Native groups in the evaluation, design, implementation and quality control of health management and services delivery systems. New methods and techniques for Indian community involvement are developed and demonstrated. ORD also coordinates health research and development activities directed to the improvement of the health of the Indian peoples.

Training for IHS, tribal and Native staff is designed to increase technical competency and accelerate the transition of program decisionmaking from non-Indian health professionals to Indian community leaders.

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A Comprehensive Approach

The Indian Health Service operates a comprehensive health services program designed to meet the needs of the Indian and Alaska Native people. The program is planned and carried out in cooperation with Indian organizations at the national, regional and local levels by Federal, State and local agencies, educational institutions, professional societies, voluntary health associations, and others.

To the extent resources permit, Indians and Alaska Natives served by the IHS receive a full range of preventive, primary medical (hospital and ambulatory), community health, and rehabilitative services. Secondary medical, highly specialized medical services, and rehabilitative care are provided by IHS staff, or through contract by non-IHS providers. Preventive health activities represent a prime focus of the IHS comprehensive health strategy. Emphasis is also placed on stimulating and enhancing Indian involvement. This includes expanding Indian manpower within the IHS in administrative and health service delivery professions, strengthening Indian influence in IHS policy formulation, and developing and improving tribes' and Native groups' abilities to manage and operate health programs.

Primary Medical Services

The IHS program is community-oriented. The foundation of the program is a system of inpatient and ambulatory care facilities which the IHS operates on Indian reservations and in Indian and Alaska Native communities. The 48 IHS hospitals (as of October 1, 1983) range in size from 12 to 170 beds. Three of these—in Phoenix, Arizona; Gallup, New Mexico; and Anchorage, Alaska—also serve as referral, training and research centers. Also within this network of health care facilities are 72 health centers, 12 school health centers, and more than 300 health stations and satellite field health clinics. Additional medical and dental clinics are held where appropriate.

Four-handed dental practice increases the efficiency of IHS hospitals and health centers. Some areas also are served by mobile dental clinics.

In places where the IHS does not have its own facilities, or is not equipped to provide a particular service, it uses contract providers such as hospitals, State and local health agencies, tribal health institutions, and individual health care providers. Services purchased through contract may include primary, secondary, and rehabilitative care, specialized diagnostic and therapeutic services, and public health and community outreach activities.

Tribally contracted health programs are conducted primarily under authority of the Indian Self-Determination and Education Assistance Act, P.L. 93-638. Enacted in 1975, this law includes the authority for Indian tribes, at their own initiative, to manage health programs or portions of programs currently operated by the IHS.

Under authority of P.L. 93-638 contracts, tribes operate 3 hospitals and 263 health clinics. Many tribes operate portions of health programs such as alcoholism, mental health, community health aid, contract health care, and environmental health service programs. As part of the congressional intent and spirit of this law, it is essential that the IHS provide technical assistance and other kinds of support to

The experience of senior IHS physicians is shared with all practitioners in arriving at the most appropriate treatments for illnesses and injuries.

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help tribes succeed in their Indian self-determination efforts.

IHS direct, contract and tribal contract-provided services presently account for approximately 4,200,000 out-patient visits and about 105,000 hospital admissions annually, plus a wide array of community health services.

IHS service unit clinical staff includes physicians, dentists, nurses, pharmacists, registered dietitians, laboratory and radiology technicians, and medical and dental assistants. Community health medics (IHS-trained physician assistants) nurse practitioners and nurse midwives complete this clinical health care team, and many times serve in remote ambulatory care facilities. The clinical staff is supported by the work of health records, engineering, housekeeping, maintenance, dietetic service, supply, administrative and clinical personnel.

Preventive Health Services

Preventive health services are provided by clinical staff at IHS and tribal facilities, and by field health personnel, forming integrated health teams which work within the Indian community. Services include prenatal, postnatal and well-baby care, family planning, dental health, nutrition, immunization, environmental health activities, and health education. Among the programs involved in the integrated approach to preventive health are community health nursing, dental health, medical social work, environmental health and health education.

Community Health Nursing

The primary focus of the IHS public health nursing program is the prevention of illness and the promotion and maintenance of health. Community health nurses are involved in planning and coordinating community programs and services, determining health needs for the individual, the family and the community, assessing health status, implementing health planning, evaluating health practices, and providing primary health care. In many of these endeavors the community health nurse works in close cooperation with other health personnel, especially community health representatives, maternal and child health aides and other indigenous auxiliary workers.

Community health nurses make house calls—in this instance by way of a 4-wheel-drive vehicle over muddy, deep rutted roads that otherwise would have been impassible.

Community health nurses help prevent complications of pregnancy and improve the general health status of expectant Indian mothers and their infants by promoting early care in pregnancy.

Early visits to the newborn in their homes and the giving of special attention to infants in high-risk families have proven beneficial in reducing morbidity and mortality. IHS community health nurses also investigate the causes of communicable diseases through home visits, strengthen health teaching in the home, the community and the clinical setting, provide counseling and guidance in health and family living to teenagers and young adults and immunize infants and children against infectious diseases.

Dental Health

Dental services are carried out in 225 IHS hospitals, health centers and other fixed facilities, and in 28 mobile dental units. In some locations, principally in Alaska, itinerant IHS dental teams with portable equipment visit isolated villages—often by aircraft or boat.

Primary dental program objectives are reduction in tooth mortality and decreases in the incidence of dental caries and in the severity of periodontal disease. Special attention by IHS practitioners is given to preventive activities which have a favorable impact on these goals.

The dental program places priority on providing preventive and corrective dental care that will result in maximum oral health for the greatest number of people. Emphasis is placed on effective measures to prevent disease and decrease

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tooth loss. Effective caries preventive measures, such as water fluoridation, that provide benefits, at the community level are encouraged. To ensure that fluoridation equipment installed in Indian community water supply systems functions efficiently and safely, dental health staff work closely with IHS environmental health program personnel and tribal workers.

Clinical services are provided on a demand care basis to all ages, with emphasis on early treatment and patient education to limit the severity of periodontal disease and caries. Special population groups including children, the homebound, elderly and handicapped individuals present special circumstances which addressed by IHS dental professionals in combination with environmental health workers, public health nurses, nutritionists and pharmacists as well as tribal health employees and volunteers.

Medical Social Work

The IHS medical social work program focuses on the social and emotional problems of patients that interfere with medical treatment. Working closely with physicians and nurses, professional social workers and para-professional associates deal with patient or patient-related staff problems such as fear of treatment procedures, adjusting to limitations imposed by medical conditions, and worry about childcare or loss of income while being hospitalized. Their clinical assessments and interventions contribute to treatment plans and continuity of care.

Another part of the medical social work program is its liaison function with community agencies. Often, problems identified in the medical setting require outside assistance such as dealing with suspected child abuse or need for nursing home placement. Knowledge of alternate resources and developed community contracts help social workers get supplemental services to patients and their families.

Environmental Health

Environmental health services form an especially important part of the IHS preventative health initiative because they attack the broad spectrum of conditions in Indian homes and communities which contribute so dramatically to high morbidity and mortality among the Indian people. The environment, which includes the home, the community and the work place, as well as the surroundings, is acknowledged to be a vital factor in the overall health and well-being of all people.

IHS sanitarians regularly inspect water treatment facilities, working in cooperation with tribal environmental health employees.

The IHS environmental health program encompasses the provision of a broad and comprehensive array of services. The staff is extensively involved in efforts to enhance the availability and quality of water used for domestic purposes in Indian homes and in the provision of safe and sanitary solid and liquid waste disposal. Related activities include environmental planning, occupational health and safety, community injury control, air, water and solid waste pollution control, and institutional environmental health in reservation areas. Staff members include environmental engineers, sanitarians, environmental health and engineering technicians, and community injury control coordinators.

Typically, environmental health program activities include:

- Continuous evaluations of changing environmental conditions and planning jointly with tribal officials for the development of comprehensive health programs.
- Participating in the investigation of communicable disease outbreaks and injuries and initiating corrective environmental control measures.
- Performing community and individual premise evaluations for determining and eliminating environmental health deficiencies.
- Providing technical assistance and training to Indian communities in the operation and maintenance of water supply and sewage disposal facilities.
- Evaluating institutional facilities operated by the Bureau of Indian Affairs and the Public Health Service, and making recommendations to the operators so that they may attain a healthful environment.
- Assisting tribes in the development and adoption of sanitary ordinances and codes.
- Identifying and recommending remedies for the causes of injury among the Indian people.

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- Working to alleviate crowded, substandard housing, unsafe water supplies and lack of sanitary disposal facilities. The basic legislation for attacking the two latter conditions is Public Law 86-1121, the Indian Sanitation Facilities Act. Since the law was passed in 1959, the IHS had, through fiscal year 1982, initiated more than 3,300 projects to provide Indian homes and communities with sanitation facilities. With the completion of all of these projects, 136,300 Indian residences (78,900 new or improved houses and 57,400 existing ones) will have been furnished with running water and a means for safe waste disposal. Much of this work has been done under cooperative agreements with the Bureau of Indian Affairs, the Department of Housing and Urban Development, the former Office of Economic Opportunity, and various Indian housing authorities.

Other projects initiated under P.L. 86-121 include engineering surveys, emergency construction, technical assistance and training for tribal employees in the use, care and maintenance of constructed facilities. The Indian people have participated in P.L. 86-121 projects by contributing labor, material and funds.

Health Education

The IHS health education program, relating to specific diseases as well as to health and safety hazards among Indians and Alaska Natives, is designed to assist them to assume greater individual, family and community responsibilities through involvement and participation. The program attempts to increase the understanding of the nature of disease and how it can be reduced, encourage more discriminating use of health services, develop Indian leadership in the assumption of responsibility for health matters, and involve more completely other agencies that have potential for contributing to the improvement of the health of this population.

The healing progress of an injured foot is evaluated by a physical therapist at an IHS hospital.

Special Health Concerns

Certain health-related problems are of special concern to the IHS and tribal leaders because of their impact on the Indian community. Among these are accidents, alcoholism, depression and other mental health problems, maternal and child health concerns, poor nutrition and aging. Many of these are associated with social disorganization. The strategy to deal with these difficult problems is centered on comprehensive preventive measures and extensive community action and control.

Alcoholism

Alcoholism and alcohol abuse continue to be leading causes of health problems among Native Americans. It is a widely held belief that 95 percent of Indians and Alaska Natives are affected either directly or indirectly by a family member's abuse of alcohol. This is confirmed by National Center for Health Statistics data which show that four of the top 10 causes of death among Indian people—accidents, chronic liver disease and cirrhosis, suicide and homicide—may be directly or indirectly related to alcohol abuse.

The National Clearinghouse for Alcohol Information notes that Indians have the highest reported frequency of problems associated with drinking when considered with other special groups. Alcoholism has been responsible for much of the social disorganization that has resulted in broken homes, violence, arrests, auto accidents, unemployment and wasting of human lives and human potential. In addition to social disorganization, alcoholism causes or contributes to an array of physical disabilities that must be treated by IHS and which drain medical care resources that are needed to address other pressing health problems.

Title II of the Indian Health Care Improvement Act, P.L. 94-437, authorized the transfer of mature (6 years of funding) Indian and Alaska Native alcoholism programs from the administrative jurisdiction of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to the IHS. To assist this transfer, as well as provide a focal point for program emphasis on alcohol abuse and alcoholism as a priority socioeconomic health problem, the IHS established a special Office of Alcoholism Programs. The transfer of all programs was completed in 1983.

IHS is giving increasing attention to the prevention of this serious problem. Many programs are attempting innovative prevention activities especially directed to the young.

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Diabetes, a major health problem among Indians, is given special attention by IHS health professionals.

Diabetes

Diabetes has become a major health problem for Indians in recent years. The complications of diabetes such as blindness, kidney failure and amputation are afflicting persons with long-standing diabetes. In 1981 diabetes was the second leading cause of adult outpatient visits to IHS facilities.

Programs are being developed throughout IHS to help the Indian and Alaska Native person understand diabetes and care for himself. Diabetes care must be adapted for the cultural and linguistic needs of patients. The model diabetes program has served as a focus for such activities.

Injuries

The second leading cause of death among Indians and Alaska Natives is accidents. During the 3-year period 1978-80, of the 19,474 Indian and Alaska Native deaths which occurred in the 28 States in which IHS has responsibilities, 3,805 deaths (19.5 percent) were due to accidents and 4,058 deaths (20.8 percent) were due to diseases of the heart. The 1980 age-adjusted death rate for accidents among Indians was 154 percent above that for all U.S. races, and the ratio of age-adjusted Indian motor vehicle accident death rates for that year compared to that for all U.S. races was 2.7 times as high.

Injury is the second leading cause of hospitalization for general medical and surgical patients in IHS and contract hospitals—12,795 discharges and 70,045 hospital days caused by injury during 1982. To help combat this problem, IHS environmental health staff members are working with other health disciplines and with tribes to develop community injury prevention and control teams and to train and offer guidance relative to home and community safety. Many tribes have set up injury control programs in which specially trained community health representatives take a leading role in reducing or eliminating the causes of injuries. Community alcoholism programs also have a role in attacking the high rate of injuries among Indians and Alaska Natives.

Maternal and Child Health

A coordinated multidisciplinary approach is being promoted in IHS service delivery areas to address the comprehensive health needs of Indian and Alaska Native children, youth and the family, emphasizing services to women in child-bearing years, infants and children. Recognizing the importance of the family as the most basic unit of our society, an objective for the 1980s is to promote family centered care in all IHS facilities providing maternal and child health (MCH) services. Sensitivity to cultural beliefs and practices relating to MCH is an important component of supporting the family structure.

Health programs for infants, children and youth range from well-child surveillance to specialty programs for the developmentally disabled and chronically and acutely ill patients. The high rate of infant morbidity and mortality is being met with emphasis on early prenatal care for the expectant woman and continuing care after she and the infant leave the hospital. Health education activities provided during the antepartum and postpartum periods assist the mother in improving caretaker and parenting skills while health education activities provided during well-child or acute illness visits enhance the parents' knowledge of normal growth and development, how to recognize illnesses requiring medical intervention, promotion of

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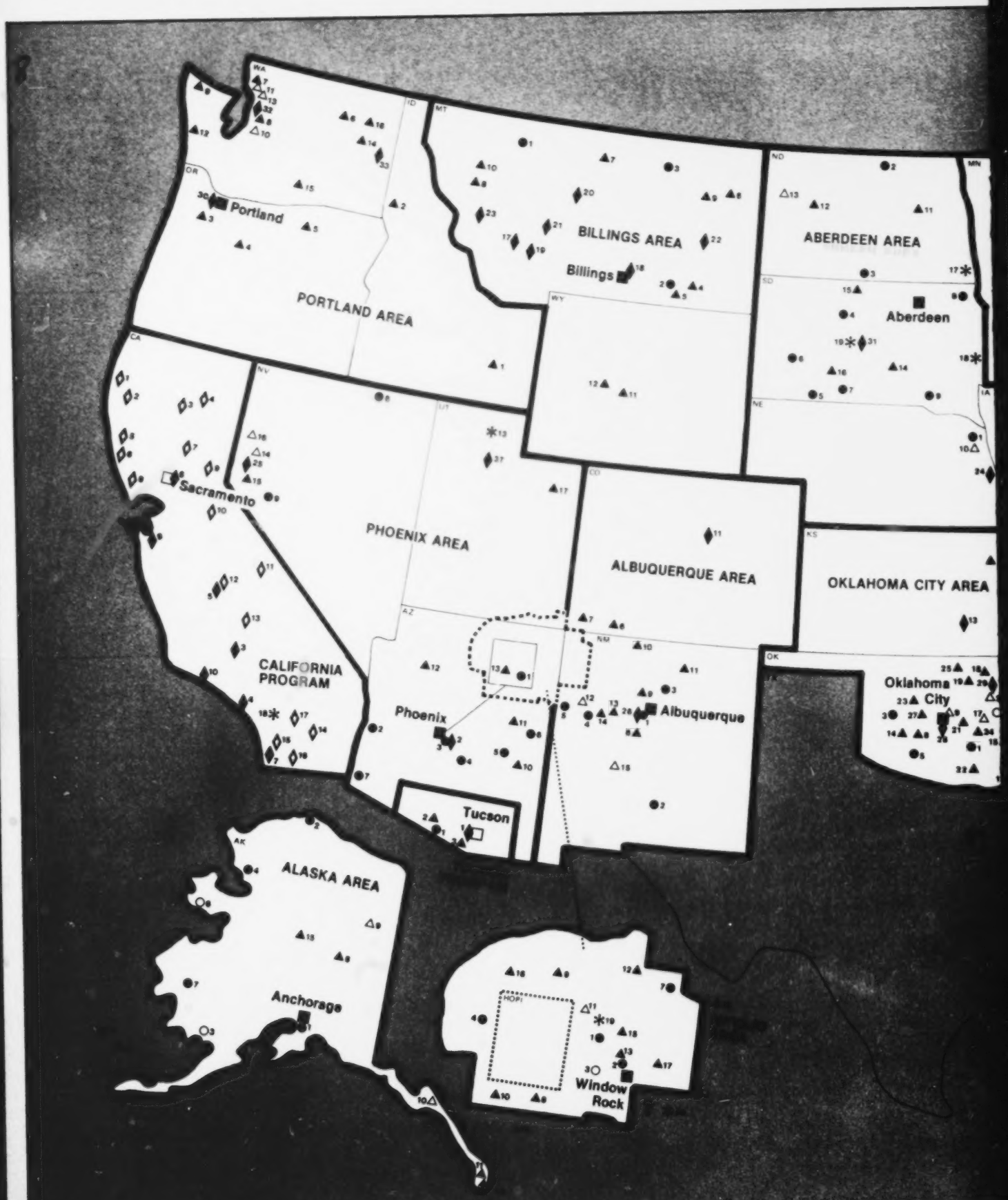

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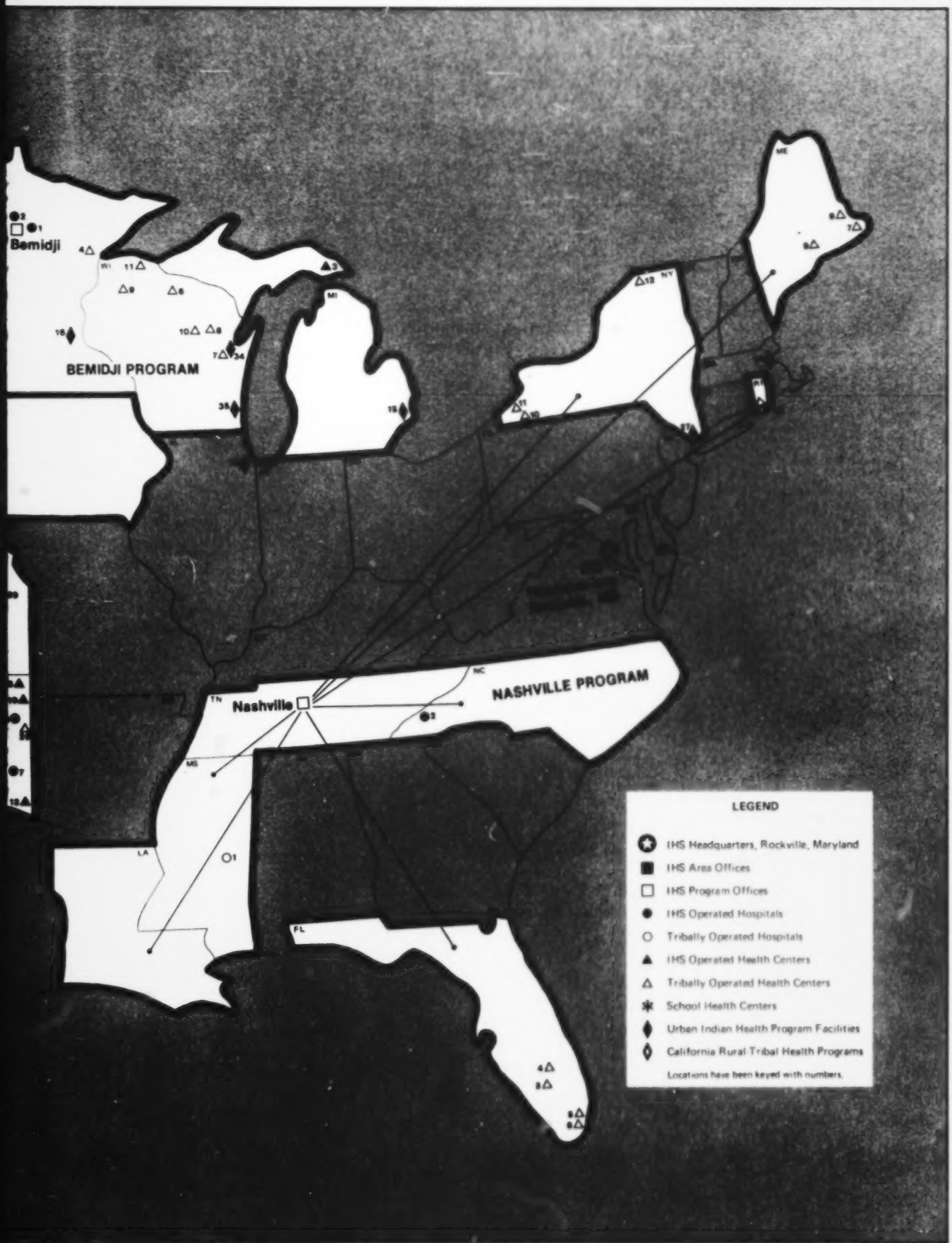

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MAJOR HEALTH FACILITIES FOR INDIANS AND ALASKA NATIVES

9a

IHS AREA OFFICES

ABERDEEN AREA
Aberdeen, South Dakota

ALASKA AREA
Anchorage, Alaska

ALBUQUERQUE AREA
Albuquerque, New Mexico

BILLINGS AREA
Billings, Montana

NAVAJO AREA
Window Rock, Arizona

OKLAHOMA CITY AREA
Oklahoma City, Oklahoma

PHOENIX AREA
Phoenix, Arizona

PORTLAND AREA
Portland, Oregon

IHS PROGRAM OFFICES

BEMIDJI PROGRAM
Bemidji, Minnesota

CALIFORNIA PROGRAM
Sacramento, California

NASHVILLE PROGRAM
Nashville, Tennessee

TUCSON PROGRAM
Tucson, Arizona

ABERDEEN AREA

● Hospitals

NEBRASKA
1 Winnebago

NORTH DAKOTA
2 Belcourt
3 Fort Yates

SOUTH DAKOTA
4 Eagle Butte
5 Pine Ridge
6 Rapid City
7 Rosebud
8 Sisseton
9 Wagner

▲ Health Centers

NEBRASKA
10 Macy*

NORTH DAKOTA
11 Fort Totten
12 New Town
13 Williston*

SOUTH DAKOTA
14 Fort Thompson
15 McLaughlin
16 Wanblee

✻ School Health Centers

NORTH DAKOTA
17 Wahpeton

SOUTH DAKOTA
18 Flandreau
19 Pierre

ALASKA AREA

● Hospitals

ALASKA
1 Anchorage
2 Barrow
3 Dillingham*
4 Kotzebue
5 Mt. Edgecumbe
6 Nome*
7 Bethel

▲ Health Centers

ALASKA
8 Fairbanks
9 Fort Yukon*
10 Juneau*
11 Ketchikan
12 Metlakatla
13 St. George
14 St. Paul
15 Tanana

ALBUQUERQUE AREA

● Hospitals

NEW MEXICO
1 Albuquerque
2 Mescalero
3 Santa Fe
4 San Fidel
5 Zuni

▲ Health Centers

COLORADO
6 Ignacio
7 Towaoc

NEW MEXICO
8 Isleta
9 Jemez
10 Dulce
11 Taos
12 Ramah*
13 Canoncito
14 Laguna
15 Magdalena*

BILLINGS AREA

● Hospitals

MONTANA
1 Browning
2 Crow Agency
3 Harlem

▲ Health Centers

MONTANA
4 Lame Deer
5 Lodge Grass
6 Poplar
7 Box Elder
8 St. Ignatius
9 Wolf Point
10 Polson

WYOMING
11 Arapahoe
12 Fort Washakie

✻ School Health Center

UTAH
13 Brigham City

NAVAJO AREA

● Hospitals

ARIZONA
1 Chinle
2 Fort Defiance
3 Ganado*
4 Tuba City

NEW MEXICO
5 Crownpoint
6 Gallup
7 Shiprock

▲ Health Centers

ARIZONA
8 Dilkon
9 Kayenta
10 Leupp
11 Rough Rock*
12 Teec Nos Pos
13 Toyei
14 Winslow
15 Tsaile*
16 Inscription House

NEW MEXICO
17 Tohatchi
18 Huerfano

✻ School Health Centers

ARIZONA
19 Many Farms

NEW MEXICO
20 Fort Wingate

OKLAHOMA CITY AREA

● Hospitals

OKLAHOMA
1 Ada
2 Claremore
3 Clinton
4 Okmulgee*
5 Lawton
6 Tahlequah
7 Talihina

▲ Health Centers

OKLAHOMA
8 Anadarko
9 Oklahoma City*
10 Jay
11 Eufaula*
12 Hugo
13 Broken Bow
14 Carnegie
15 McAlester
16 Miami
17 Okemah*
18 Pawhuska
19 Pawnee
20 Sapulpa*
21 Shawnee
22 Tishomingo
23 Watonga
24 Wewoka
25 Ponca City
26 Stilwell*
27 Concho

KANSAS
28 Holton
29 Lawrence

PHOENIX AREA

● Hospitals

ARIZONA
1 Keams Canyon
2 Parker
3 Phoenix
4 Sacaton
5 San Carlos
6 Whiteriver
7 Yuma

NEVADA
8 Owyhee
9 Schurz

▲ Health Centers

ARIZONA
10 Bylas
11 Cibecue
12 Peach Springs
13 Second Mesa

NEVADA
14 Sparks*
15 Stewart
16 Washoe*

UTAH
17 Roosevelt

✻ School Health Center

CALIFORNIA
18 Riverside

PORTLAND AREA

▲ Health Centers

IDAHO
1 Fort Hall
2 Lapwai

OREGON
3 Salem
4 Warm Springs
5 Pendleton

WASHINGTON
6 Nespelem
7 Bellingham
8 Auburn
9 Neah Bay
10 Puyallup*
11 LaConner*
12 Taholah
13 Marysville*
14 Wellpinit
15 Toppenish
16 Inchelium

BEMIDJI PROGRAM

● Hospitals

MINNESOTA
1 Cass Lake
2 Red Lake

▲ Health Centers

MICHIGAN
3 Kincheloe

MINNESOTA
4 Cloquet*
5 White Earth

WISCONSIN
6 Lac du Flambeau*
7 Oneida*
8 Keshena*
9 Hayward*
10 Bowler*
11 Odanah*

NASHVILLE PROGRAM

● Hospitals

MISSISSIPPI
1 Philadelphia*

NORTH CAROLINA
2 Cherokee

▲ Health Centers

FLORIDA
3 Clewiston*
4 Okeechobee*
5 Hollywood*
6 Miami*

MAINE
7 Perry*
8 Princeton*
9 Old Town*

NEW YORK
10 Salamanca*
11 Cattaraugus*
12 Hogansburg*

RHODE ISLAND
13 Kenyon*

TUCSON PROGRAM

● Hospital

ARIZONA
1 Sells

▲ Health Centers

ARIZONA
2 Santa Rosa
3 San Xavier (Tucson)

CALIFORNIA PROGRAM

◊ Rural-Tribal Health Program

CALIFORNIA
1 Trinidad
2 Hoopa
3 Anderson
4 Burney
5 Covelo
6 Ukiah
7 Oroville
8 Santa Rosa
9 Auburn
10 Tuolumne
11 Bishop
12 Clovis
13 Porterville
14 Banning
15 Valley Center
16 El Cajon
17 San Bernadino

◆ URBAN INDIAN HEALTH PROGRAMS

ARIZONA
1 Tucson
2 Phoenix

CALIFORNIA
3 Bakersfield
4 Compton
5 Fresno
6 Sacramento
7 San Diego
8 San Francisco
9 San Jose
10 Santa Barbara

COLORADO
11 Denver

ILLINOIS
12 Chicago

KANSAS
13 Wichita

MASSACHUSETTS
14 Boston

MICHIGAN
15 Detroit

MINNESOTA
16 Minneapolis

MONTANA
17 Anaconda
18 Billings
19 Butte
20 Great Falls
21 Helena
22 Miles City
23 Missoula

NEBRASKA
24 Omaha

NEVADA
25 Reno

NEW MEXICO
26 Albuquerque

NEW YORK
27 New York City

OKLAHOMA
28 Oklahoma City
29 Tulsa

OREGON
30 Portland

SOUTH DAKOTA
31 Pierre

WASHINGTON
32 Seattle
33 Spokane

WISCONSIN
34 Green Bay
35 Milwaukee

TEXAS
36 Dallas

UTAH
37 Salt Lake City

As of 4/1/84

*Tribally Operated

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Top—Registered pharmacists dispense from modern facilities at IHS hospitals.

Left—Tribally operated and staffed ambulances transport ill and injured persons to many IHS and contract health care facilities. Some hospitals also are equipped with helicopter landing pads and many have small aircraft landing strips nearby.

Top—Physician assistants and nurse practitioners are beneficially employed in many IHS hospitals and health centers.

Bottom—More than 60 percent of Indian Health Service employees are Indians or Alaska Natives.

Emergency medical teams in Alaska often use snow-mobiles and sleds to transport injured or ill patients to village clinics—where community health aides are in radio or telephone contact with hospital physicians.

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good health habits and the benefits to be derived from regular visits to the clinic for well-child health supervision.

The goal of the health service activities for women is to provide health promotion and maintenance services relating to childbearing (obstetrics) and the reproductive cycle (gynecology) which also include prevention, intervention and rehabilitative services. Family planning services to protect the health of women and promote a happy and healthy family environment are important components of the comprehensive program.

Mental Health

As the Indian and Alaska Native people have been caught increasingly more in the conflict between their traditional cultures and the demands of modern society, mental health problems have increased. The seriousness is demonstrated by their 1980 age-adjusted suicide rate which is 1.2 times as high as that of the U.S. all races population, and by their homicide rate which is 1.7 times as high.

Emotional problems and behavior disorders are frequent among Indian children in their struggle for identity and achievement of self-sufficiency in a new social structure. There is an increasing need for mental health involvement in child guidance and counseling, and for the development of new and effective methods to prevent further trauma to the growing child.

Programs being developed by the IHS are aimed at helping the Indian person overcome cultural and linguistic barriers. Before the initiation of these programs Indian people in need of care often were referred to psychiatrists and other professionals little acquainted with the realities of Indian life. The resulting encounters often were confusing and discouraging to both patient and psychiatrist.

The IHS mental health effort incorporates two essential requirements—a continuing effort to understand Indian life, ideas and language; and extensive Indian involvement in the program.

Nutrition

Promotion of optimal nutrition and nutritional care are essential components of every well-planned health program and are especially significant for quality health for Indians and Alaska Natives. For those considered at nutritional risk—infants, pre-school children, adolescents, pregnant and lactating women, the elderly and the chronically ill—sound nutrition practices are essential.

In the IHS, nutritional care is an integral part of health services delivery. Emphasis is placed on incorporating nutrition education into every available health, social and education service and food assistance program.

The nutrition and dietetics program includes preventive and direct patient care nutrition services, operation of the dietetic departments in IHS hospitals, training and career development for Indians in food service and community nutrition, advocating the improvement of the quantity and nutritional quality of the Indians' food supply, and in-service education and training.

Otitis Media

Otitis media, a disease of the middle ear, replaced tuberculosis as the Indians' major health problem prior to 1971 when the IHS Otitis Media Program was initiated with special funding from the Congress. With additional funding appropriated in 1974, the IHS established otitis media programs in each administrative area, expanded preventive efforts, increased casefinding and treatment of acute cases, intensified treatment of chronic patients and the correction of its complications, and expanded rehabilitative measures.

As a result of these programs, in many areas the incidence of chronic otitis media has now been reduced to a level equal to or less than the rate observed in the national non-Indian population. At selected facilities, efforts aimed at communication disorders such as speech and language deficiences have been undertaken along with the establishment of speciality clinics serving children with disfigured faces, learning disabilities, deafness and related health programs. Additionally, through the hearing aid program, many persons of all ages have regained lost communication and social abilities.

Aging

Life expectancy at birth for Indians and Alaska Natives has increased from 60.0 years during 1949-51 to 71.1 years during 1979-81. This number of Native Americans 45 years or older has increased from 16.2 percent in 1960 to 18.2 percent in 1980. This in turn has created a greater demand for health and social services for ambulatory, home-bound and institutionalized aging and aged persons.

The IHS, in response, is placing special attention on health assessments, with timely follow-up to prevent unnecessary illness and disability. At the same time, services are being expanded in areas of primary concern to the elderly, for example, diabetes and arthritis.

Professionals providing comprehensive health care services include, back row from left, hospital administrator, radiologist, clinical nurse, community health nurse, construction engineer, internal medicine specialist, front row, pharmacist, X-ray technician, dental technician, sanitarian, and pediatric nurse practitioner.

Many kinds of human skills are needed by the Indian Health Service in carrying out its mission. Two avenues for obtaining these are recruitment and career development activities. Staff education, training and structured assignments for IHS employees are vehicles for improving program management, providing skills for special needs, promoting employee career development, and improving the effectiveness of consumer participation. Training opportunities also are available to Indian and Alaska Native advisory health board members and tribal and corporation health program management staff and health services workers.

The IHS offers career opportunities in a wide range of professional health, allied health, administrative and other fields under the Federal Civil Service and U.S. Public Health Service Commissioned Corps personnel systems. Opportunity to choose practice sites often exists for physicians, dentists, nurses and other health professionals.

A policy of Indian preference is followed in recruitment and career development training. Currently, more than half of the IHS staff is of Indian or Alaska Native descent. Many of these, in addition to their regular duties, provide valuable interpretive, educational and motivational services.

Professional Training

Education, training and career development opportunities for IHS professional staff include specialty training in public health for physicians, dentists, nurses and others, physician residency training in pediatrics, surgery and obstetrics-gynecology, a dental residency program and a pharmacy internship. Continuing education seminars and specialty workshops for health care professionals and paraprofessionals are conducted by the staff of the Clinical Support Center in facilities at Phoenix, Arizona, at the Black Hills Training Center, Rapid City, South Dakota, and at selected locations.

Nursing Careers for Indians

Indians and Alaska Natives are among the most under-represented of any group in the health professions field, and consequently, the number available for work in the Indian community is low. Authorizations contained in Title I of the Indian Health Care Improvement Act seek to change this.

One health professions field in the IHS in which Indians have made notable strides in recent years is nursing. Now approximately a fourth of its 1,941 professional nurses are of Indian or Alaska Native descent. These strides have been made through the efforts of the nursing program which has placed emphasis on seeking to recruit Indian nurses. The IHS also supports nursing education programs that are designed to provide Indian employees with the opportunity to obtain a degree in nursing. An IHS-supported program in Albuquerque, New Mexico allows Indian licensed practical nurses to study to become registered nurses with an associate or baccalaureate degree, thus providing them and the IHS with enhanced professional skills.

COSTEP

The IHS participates in the Public Health Service-sponsored COSTEP (Commissioned Officers

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Student Training Extern Program), which offers health professions students an opportunity to gain experience within the health program environment. A limited number of students are commissioned as reserve officers in the PHS Commissioned Corps and are called to active duty during free periods of the academic year. These officers may serve in any of the IHS facilities or programs. Many students who participate in this program subsequently enter career service in the IHS.

Work-Study Programs

Work-study and cooperative education arrangements have been developed with many high schools, colleges and universities to encourage Indian students to prepare for health careers while working in their home communities. Counseling programs also have been established to identify and place Indian students in health programs.

Allied Health Training

Allied and auxiliary health personel of the IHS, tribes and Native corporations are vital in providing health care for Indians and Alaska Natives. By supplementing the work of health professionals, these paraprofessionals help make health services more accessible and comprehensive, strengthen continuity and increase Indian involvement in health activities.

Among the careers for which training is available are community health representative, community health aide, medical laboratory technician, audiometric technician, health records technician, environmental health technician, dental assistant, optometric assistant, mental health worker, medical social work associate, food service supervisor and nutrition aide. On-the-job training is provided for such positions as nursing assistant, food service worker and medical records clerk.

Community Health Representative

Community health representatives (CHR) are Indian people who are selected, employed and supervised by their tribes and trained to meet specific tribal health needs. The CHR program is designed to improve communications between the Indian community and providers of health services as well as increase basic health care and instruction.

CHRs receive training at the IHS Training Center in Rapid City, South Dakota and at local training facilities. The curriculum includes classroom study and field experience supervised by professional medical and health personnel. CHRs learn the concepts of health and disease, basic health skills, home nursing, first aid, nutrition, health education and environmental health. Principles of communication, group organization and planning as well as how to conduct meetings are also taught. Almost 1,800 CHRs are now providing services to their people.

Community Health Aide

The Community Health Aide (CHA) program was developed in Alaska to educate selected village residents to provide primary health care and to give support to the community health aide working there. Remote villages depend on the CHA for first-line primary health care and as the initial responder for emergency care. A wide range of preventive health services provided by the CHA are

Community health aides in 130 Alaska villages are linked by radio and/or telephone to hospitals. These paraprofessionals give first aid, examine the ill, report symptoms to the physician and carry out recommended treatment.

coordinated with native health corporations, the State and IHS health care programs. Professional support and collaboration are provided by the physician staffs in various Alaska Area Native Health Service and native corporation-administered hospitals. More than 300 CHAs in 200 villages have been trained to provide these valuable health care services.

Medical Laboratory Technician

As part of its laboratory improvement program, the IHS conducts a 2-year program to train medical laboratory technicians for its facilities. Training is conducted at the Navajo Community College in Tsaile, Arizona, and at the PHS Indian Medical Center in Gallup, New Mexico.

Environmental Health Technician

Training in the basic elements of communicable disease transmission, sanitary practices, and health education techniques is available to Indians who wish to work in environmental health. Instruction also is provided in community environmental health practices such as epidemiology, water supply, waste disposal, institutional sanitation, occupational health and community

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injury control, as well as managerial aspects of these programs.

Dental Assistant

A 1-year program at Haskell Indian Junior College in Lawrence, Kansas, trains high school graduates to be dental assistants. Students are trained in chairside assisting, preventive services and efficient dental practice management. The training program is accredited by the American Dental Association and graduates are eligible for certification after taking the required examination.

These Indian and Alaska Native dental assistants contribute significantly to the IHS dental program, increasing dental team-provided services by more than 30 percent.

Optometic Assistant

Programs varying in length from 3 weeks to more than a year are available at many vocational, technical and community colleges to train persons to serve as vision paraprofessionals. Optometric assistants are employed to perform in the delivery of eye care at IHS optometry and opthalomology clinics. These persons provide optical support and direct patient care assistance to the professionals in IHS facilities and in tribal clinics. Where direct eye care is not available, individuals are trained as eye care coordinators to provide direct optician support for the tribe.

Mental Health Worker

The mental health worker is an essential member of the IHS health care team. These paraprofessional health workers are Indians or Alaska Natives who are knowledgeable about the psychological and social aspects of the people they serve. Appreciating Indian attitudes toward health and illness, such workers are highly sensitive to the needs of the communities in which they work. As such, they are instrumental in bringing about communications between the Indian patient and the non-Indian medical provider and acceptance of mental health activities by the Indian community.

Mental health workers are trained to assist psychiatrists, psychologists, psychiatric social workers and other mental health professionals in providing therapy services in the Indian community, in schools, and in hospitals and health centers.

Nutrition and Dietetics

Because of increased national interest in nutrition and related problems, and the plans developed to implement legislation, the IHS expanded nutrition training for both IHS and tribal employees. Established tribal food and nutrition programs such as day care, Headstart, Women, Infants and Children (WIC), supplemental food program, group care facilities and halfway houses, rehabilitation centers, nursing homes, senior citizens centers and food assistance programs have increased the need for trained nutrition personnel. To meet these additional needs, the IHS has increased opportunities by offering a variety of short term courses. The goals of the nutrition and dietetics training programs are to improve the quality of services and to offer career development opportunities for Indians and Alaska Natives.

Tribal Leadership Training

The IHS sponsors and encourages leadership training for Indians serving on local and area health boards, the National Indian Health Board, and in other tribal capacities. Emphasis on this training has increased over the years as more Indians and Alaska Natives have become actively involved in the management of their health affairs. Training programs are conducted at the Tribal Management Support Center in Tucson, Arizona, and include management and supervision, personnel development, financial and budget management, computer services, and other subjects needed to meet stated tribal and community needs.

IHS Manpower Program

Title I of the Indian Health Care Improvement Act (P.L. 94-437) provides for the establishment of a manpower program designed to meet the needs of the IHS. The long-range objective is in Section 101:

> "The purpose of Title I is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians."

Five sections in the title support these objectives. Each provides a mechnism to accomplish the broad objectives by establishing specific programs and funding authorizations. Sections and their objectives are: 102) Health Professional Recruitment Program for Indians; 103) Health Professions Preparatory Scholarship program for Indians; 104) Health Professional Scholarship Program; 105) Indian Health Service Extern Program; and 106) Continuing Education Allowances.

Title I also provides the legislative mandates to achieve the objective of "...assisting Indian tribes in developing their capacity to man and manage their health programs through activities which include health and management training."

Role of Indians and Alaska Natives

Tribal health councils meet periodically to provide guidance to IHS service units. This group approved purchase of this artwork for hanging in the lobby of a newly opened hospital.

Over the past decade, tribally established community health boards, representing the tribes served by IHS service units, have helped develop local program policy, determine needs and priorities and allocate resources. Area advisory bodies, composed of representatives of the community health boards within each IHS area, perform similar functions.

These groups are, in turn, represented by the National Indian Health Board, headquartered in Denver, Colorado, which, together with other organizations such as the National Tribal Chairmen's Association and National Congress of American Indians, work with the IHS at the national level.

Indian involvement in program implementation is equally important. From the start it was recognized that community involvement was essential to the treatment, prevention and control of unfavorable health conditions. Elements of local community involvement have continued to expand.

Tribes and Native corporations also are provided technical assistance to develop or strengthen health boards and departments, and to train staffs in administrative and management skills. This has been expanded with the 1975 passage of the Indian Self Determination and Education Assistance Act, P.L. 93-638. Urban Indian health projects also receive IHS technical assistance.

The scope of program activities managed by tribes and Native corporations is wide. It includes community health, mental health, alcoholism and injury control services as well as activities such as program planning and evaluation, training and the planning, construction and operation of health facilities.

Large-scale examples of Indian organizations involved in the implementation of IHS program activities are the California Rural Indian Health Board and the United South and Eastern Tribes which deliver a variety of health services in wide geographic areas.

The IHS also helps Indians and Alaska Natives to identify and seek out Federal resources applicable to their health, social and economic problems.

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Health services for Indians began in the early 1800s when Army physicians took steps to curb smallpox and other contagious diseases among tribes living in the vicinity of military posts. Treaties committing the Federal Government to provide health services were introduced in 1832 when a group of Winnebagos was promised physician care as partial payment for rights and property ceded to the government. Although most treaties imposed time limits of 5 to 20 years for provision of care, the Federal Government adopted a policy of continuing services after the original benefit period expired.

Transfer of the Bureau of Indian Affairs from the War Department to the Department of the Interior in 1849 stimulated the extension of physicians' services to Indians by emphasizing nonmilitary aspects of Indian administration and by developing a corps of civilian field employees. Within 25 years, about half of the Indian agencies has a physician, and by 1900 the Indian Medical Service employed 83.

Nurses were added to the staff in the 1890s and their numbers grew from 8 in 1895 to 25 in 1900. Most were assigned to Indian boarding schools. Beginning in 1891, field matrons were employed to teach sanitation and hygiene, provide emergency nursing service and prescribe medicine for minor illnesses—activities which later were taken over by public health nurses.

Indian Bureau policy by the late 1880s clearly directed physicians to promote preventive activities, but efforts were limited until well after the turn of the century because the emphasis largely was curative.

The first Federal hospital built for Indians was constructed in the 1880s in Oklahoma and a concentrated movement was under way before 1900 to establish hospitals and infirmaries on every reservation and at each boarding school. The reasons for construction were the isolation in which Indians lived, the lack of nearby facilities, and home conditions which made prescribing a course of treatment outside a hospital often useless and sometimes dangerous to the patient.

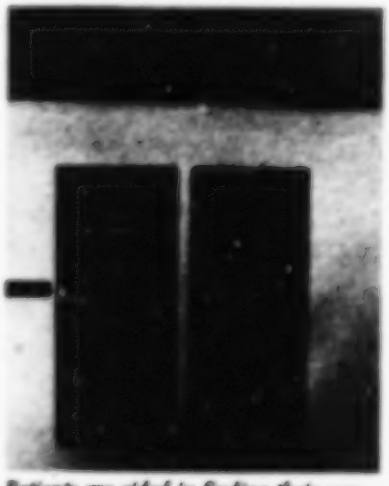
Professional medical supervision of health activities for Indians was begun in 1908 with the establishment of the position of chief medical supervisor, and was strengthened in the 1920s by the creation of the Health Division and appointment of district medical directors. The first appropriation specifically for general health services to Indians was made in 1911. The basic legislation for IHS to provide services to Indians is the Snyder Act of 1921 which authorizes the expenditure of funds "for relief of distress and conservation of health of Indians throughout the United States." In 1926, medical officers of the Public Health Service Commissioned Corps were detailed to certain positions in the program.

Individual disease control programs, such as tuberculosis, were begun early in the 1900s, and health education activities to support these programs were introduced in 1910. Dental services began in 1913 with the assignment of five itinerant dentists to visit reservations and schools. Pharmacy services were organized in 1953 with PHS pharmacy officers assigned to headquarters, area offices and hospitals.

Until the late 1920s sanitation services did not extend beyond occasional "clean-up" campaigns and physicians' inspections of homes, schools and Indian agencies. In 1928, PHS sanitary engineers began assistance to the Bureau of Indian Affairs in surveying water and sanitation systems and investigating other problems, usually restricted to Bureau installations. An expanded program to improve sanitation in individual homes was begun in 1950.

Congress passed the Transfer Act, P.L. 83-568, in 1954. In 1955 responsibility for Indian health was transferred from the Department of the Interior to the Department of Health, Education, and Welfare's Public Health Service. At the time, both medical facilities and personnel were inadequate to meet the Indians' health needs.

The initial program priorities for the PHS's new Division of Indian Health were 1) to assemble a competent health staff, 2) establish adequate facilities where services could be provided, 3) institute extensive curative treatment for the many Indians who were seriously ill, and 4) develop and initiate a full-scale preventive program which would reduce the excessive amounts of illnesses and early deaths, especially from preventable diseases.



Patients are aided in finding their way around this IHS hospital by appropriate symbols.

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Since 1955 the Division of Indian Health, now the Indian Health Service, has assumed more responsibilities and has expanded its staff from a small corps of health professionals to more than 9,000 skilled and dedicated men and women. The number of physicians in the program has risen from 125 to 600, dentists from 40 to 250, and registered nurses from 780 to 2,000. To its original health staff of clinical physicians and nurses, dentists, pharmacists and sanitary engineers, the program has added field health physicians, registered record administrators, public health nurses, registered dietitians, public health nutritionists, community health medics and aides, practical nurses, dental assistants, maternal and child health specialists, environmental sanitarians, and auxiliaries in a number of categories.

Over the past 29 years, 27 hospitals, 26 health centers and 58 field health stations have been built. Major alterations have been made at many facilities, and currently several are in various stages of contruction. Through Public Law 85-151, 165 beds to serve Indians and Alaska Natives have been added to 20 community hospitals which were constructed with assistance from Hill-Burton Act (Title VI of the Public Health Service Act) funding.

Additionally, capabilities have been expanded through numerous education and training activities designed to increase efficiency, augment manpower resources and promote career development.

Dramatic increases in the use of services also have occurred. Virtually all Indian births (99.1 percent in 1981) occur in hospitals today. Annual admissions to IHS and contract hospitals have more than doubled; outpatient visits made to

Ultrasound and other modern sophisticated diagnostic equipment are efficiently used at IHS health care facilities.

hospitals, health centers and field clinics (including contract and tribal facilities) have increased 8.2 times; and the number of dental services provided is 9 times greater.

Many Indian tribes and intertribal organizations now are managing and operating IHS programs and services in their communities. While providing Indian people the opportunity to become involved in the shaping and administration of their own health affairs has always been a program objective, other priorities kept the IHS from giving this need optimal attention in the early years. The Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act have provisions to assist tribes desiring to assume responsibility for their health programs.

Indian Resource Liaison

The Indian Resource Liaison Staff (IRLS) was established in 1980 as a component of the Division of Program Formulation to serve as a national focal point to provide policy guidance to IHS staff, tribes, tribal organizations and urban organizations in 1) implementing special Indian legislation and authorities; 2) formulating necessary policies; 3) developing, planning and implementing a policy information and dissemination system; and 4) coordinating development of policy guidance materials. IRLS functions include responding to assignments and inquiries about P.L. 93-638 contracts and grants, and other Indian legislation, and serving as ombudsman, problem-solver and adviser to IHS staff and tribal/urban officials.

IRLS develops and distributes 1) Indian Self-Determination Memoranda which establish and communicate policy affecting IHS operations related to tribal P.L. 93-638 contracts, and 2) Indian Self-Determination Advisories which briefly address and highlight particular issues of interest. Technical assistance is also provided to tribes and tribal organizations and to IHS staff in identifying problems and implementing solutions to promote the Indian self-determination process.

Equity Health Care Fund

In fiscal year 1981 the Congress established the Equity Health Care Fund and provided resources for its implementation. The intent of this initiative is to provide priority funding to those tribes with the greatest level of unmet health needs. The IHS goal is to achieve comparability in the funding for health services among tribes. The funds received in FY 1981 were directed to 51 tribes in Level V (81-100 percent unmet health needs) of the health services priority system. The FY 1982 equity funds went to 4 tribes in Level V and 100 tribes in Level IV (61-80 percent unmet). In FY 1983, these funds were directed to 10 tribes in Level V and 54 tribes in Level IV. FY 1984 is the final year of funding under this initiative.

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Health levels among Indians and Alaska Natives have substantially improved. From 1954-56 to 1978-80 3-year infant death rates declined from 62.7 to 14.6 per 1,000 live births; tuberculosis death rates are down 94 percent; gastrointestinal disease death rates are down 90 percent, and death rates from pneumonia and influenza are down 73 percent.

Tuberculosis, once the No. 1 scourge of Indians and Alaska Natives, has been dramatically contained. In 1956, for example, the IHS had 3,606 such admissions to PHS Indian and contract hospitals. In fiscal year 1977, there were only 194 admissions. This represents a decline of 95 percent. New active case rates of tuberculosis also have been dramatically reduced. Fiscal year 1982 figures show that they are down 86 percent since 1962.

There are other manifestations of better general health reflected in a leveling off of hospitalizations and a continuing large increase in clinic visits, signifying less severe illnesses and fewer people requiring prolonged hospital care. These changes indicate a stabilization of therapeutic health activities and the growing acceptance of health maintenance measures by Indians and Alaska Natives.

Age of the Population

According to the 1980 Decennial Census, the median age of Indians and Alaska Natives residing in States served in part or in total by the IHS was 22.4 as compared with a median age of 30.0 years for the U.S. population as a whole. Recent census age data indicate that there has been a slight change in the age structure of the total U.S. population. The median age of the U.S. population was estimated to be 30.6 years as of July 1, 1982. This is an increase of approximately 7 months over the 1980 figure. Similar changes also have occurred in the median age for Indians. A preliminary estimate for 1982 based on the increase from 1970-1980 is 23.0 years.

The percentage of Indian and Alaska Native babies born in hospitals has grown from 88.2 in 1955 to 99.0 in 1981.

Vital Events

Birth Rates (Live Births Per 1,000 Population)

Indian and Alaska Native (1978-80)	30.5
U.S. All Races (1979)	15.9

Indian and Alaska Native birth rates, after steadily increasing from 1955 through 1965, have declined since. The birth rate in 1954-56 was 37.5 per 1,000 population, reaching its peak in 1959-61 with a rate of 42.1. In 1978-80 the Indian and Alaska Native birth rate was almost twice that for the U.S. all races.

Infant Death Rates Per 1,000 Live Births

Indian and Alaska Native (1978-80)	14.1
U.S. All Races (1979)	13.1

The Indian and Alaska Native infant death rate has declined about 77 percent since 1954-56, and is now 0.7 times that of the general population.

Neonatal Death Rates Per 1,000 Live Births

Indian and Alaska Native (1978-80)	7.3
U.S. All Races (1979)	8.9

The death rate among Indian and Alaska Native infants under 28 days of age has declined 68 percent since 1954-56 and is now lower than that for the general population. In 1980, 99.1 percent of Indian and Alaska Native births occurred in hospitals. This slightly

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In Alaska, the IHS operates five hospitals with a total of 343 beds.

exceeds the 1980 U.S. proportion of 99.0 percent. Major causes of neonatal deaths include congenital anomalies, respiratory distress syndrome, disorders relating to short gestation and unspecified low birth weight, and newborn affected by maternal complications of pregnancy.

Post-Neonatal Death Rates Per 1,000 Live Births

Indian and Alaska Natives (1978-80)	7.2
U.S. All Races (1979)	4.2

The death rate among Indian and Alaska Native infants 28 days through 11 months of age since 1954-56 has been reduced by 82 percent, but is almost 1.7 times as high as that for the general population. In 1965-67 the Indian and Alaska Native rate (20.7) was 3 times as high as the rate for the general population in 1966 (6.5). The chief causes of post-neonatal deaths are sudden infant death syndrome (SIDS), congenital anomalies, accidents and adverse effects, penumonia, meningitis, gastritis, duodenitis and non-infective enteritis and colitis.

Leading Causes of Death (1979-1980)

Leading causes of death among Indians and Alaska Natives were diseases of the heart, accidents, malignant neoplasms, chronic liver disease and cirrhosis, cerebrovascular disease, pneumonia and influenza. These seven causes of death, which accounted for 65 percent of the total Indian and Alaska Native deaths in 1978-80, have changed little over the years. Accidents are a major cause of death with a 1980 age-adjusted death rate of 107.3 per 100,000—2.5 times that of the general population (42.3).

Use of Facilities and Services

The estimated number of Indians and Alaska Natives eligible for IHS services in 1985 is about 931,000. Most live on or near reservations in 28 States and in isolated villages in Alaska. Following are estimated numbers by IHS administrative areas:

Aberdeen Area (S Dak., N. Dak., Nebr., Iowa)	72,000
Alaska Area	73,000
Albuquerque Area (Parts of N. Mex., and Colo.)	52,000
Bemidji Program (Mich., Minn., Wisc.)	48,000
Billings Area (Mont., Wyo.)	41,000
California Program	72,000
Nashville Program (Fla., La., Maine, Miss., N.C., N.Y., Penna.)	29,000
Navajo Area (Parts of Ariz., N. Mex., Utah)	166,000
Oklahoma City Area (Okla., Kans.)	192,000
Phoenix Area (Parts of Ariz., Nev., Utah)	84,000
Portland Area (Idaho, Ore., Wash.)	85,000
Tucson Program (Part of Ariz.)	18,000

PHS Indian and Contract Hospitals

The Indian Health Service operates 48 general hospitals, most of which are located in Alaska, Arizona, New Mexico, Oklahoma and South Dakota. The range of services provided includes medicine and surgery, obstetrics, tuberculosis and neuropsychiatry. The total available beds in IHS hospitals in FY 1983 numbered 2,148 (excluding bassinets). In addition to the PHS Indian hospitals, about 1,000 beds are available through contractual arrangements with several hundred community general hospitals and State and local government tuberculosis and mental hospitals.

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Illnesses Requiring Hospitalization

Illnesses and diseases for which Indian and Alaska Natives are hospitalized provide important indices for identifying health problems. Leading causes of hospitalization in FY 1983 were:

1. Complications of pregnancy, childbirth and puerperium
2. Injuries and poisonings
3. Digestive system diseases
4. Respiratory system diseases

Hospital Inpatient Services

Discharges for persons under 15 years old accounted for 19.7 percent of the total number in 1983. This compares with 25.7 percent in 1973. The percentages in the other age categories have all increased since 1973.

Percent Distribution by Age Group IHS and Contract General Hospitals - FY 1983 and 1973

Age Group	*1983*	*1973*
Under 15 years	19.7	25.7
15-44 years	54.8	51.4
45-64 years	15.0	14.4
65 years and older	10.5	8.5

Admissions to all hospitals including those under contract, increased about 110 percent between 1955 and 1983. Approximately 25 percent of the admissions in 1983 were to contract hospitals. The types of admissions were distributed:

Types of Medical Service	*Number*	*Percent of Total*
Medical and Surgical		
Adult	57,593	55.9
Pediatric	19,948	19.4
Obstetric	23,700	23.0
Other	1,720	1.7
Total	102,961	100.0

Laboratories at IHS hospitals and health centers are highly automated, providing increased efficiency.

Outpatient Visits 1983

To PHS Indian hospital clinics	1,955,462
To health centers, field clinics, schools and other units	1,297,239
To facilities operated by tribes	675,181
To contract physicians	225,000
Total	4,152,882

Dental Services 1983

	IHS and Tribal Dental Clinics	*Contract Dentists*
Patients Examined	241,400	26,655
Corrective and Preventive Services	1,673,333	190,406

Vision Services 1983

	IHS	*Contract*
Vision Examinations (Refractive)	70,326	22,451
Glasses Provided		47,527

All optometric care prior to 1966 was provided by contract. Since then the IHS optometric staff has grown to 35, supported by an optometric assistant in most locations. Ophthalmologists, at some of the larger facilities, provide medical and surgical eye care, and supplement refractive care. Vision screenings, eye care, safety education programs and specialty services also are provided through IHS and tribal facilities.

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IHS Hospitals

The Indian Health Service currently operates 48 hospitals. Pictured is the Phoenix Indian Medical Center.

Location	No. of Beds	Outpatient Visits 1983
Alaska		
Anchorage	170	94,899
Barrow	14	18,847
Kotzebue	31	19,667
Mt. Edgecumbe	78	17,592
Bethel	50	45,883
Arizona		
Chinle	12	22,945
Ft. Defiance	68	68,797
Keams Canyon	38	31,902
Parker	20	19,484
Phoenix	163	97,434
Sacaton	20	36,688
San Carlos	36	34,932
Sells	40	37,130
Tuba City	103	93,034
Whiteriver	46	55,002
California		
Ft. Yuma	17	15,712
Minnesota		
Cass Lake	21	24,910
Red Lake	23	36,666
Mississippi		
Philadelphia	40	23,767
Montana		
Browning	34	44,214
Crow Agency	34	32,737
Harlem	18	19,956
Nebraska		
Winnebago	38	22,956
Nevada		
Owyhee	15	8,731
Schurz	14	8,997
New Mexico		
Acoma-Laguna	40	24,862
Albuquerque	54	43,756
Crownpoint	34	31,433
Gallup	115	113,702
Mescalero	15	21,486
Santa Fe	55	34,270
Shiprock	42	74,124
Zuni	45	33,423
North Carolina		
Cherokee	35	50,206
North Dakota		
Belcourt	46	56,508
Ft. Yates	32	22,712
Oklahoma		
Ada	53	56,267
Claremore	60	83,514
Clinton	14	13,275
Lawton	52	52,720
Tahlequah	40	88,789
Talihina	52	30,510
South Dakota		
Eagle Butte	35	28,727
Pine Ridge	58	46,388
Rapid City	39	36,056
Rosebud	29	37,858
Sisseton	26	20,615
Wagner	26	21,504
Totals		
Hospitals		48
Beds Available		2,148
Outpatient Visits-1983		1,955,587

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IHS Health Centers

There are 79 health centers providing outpatient care for the entire family.

Location	Visits in 1983
Alaska	
Fairbanks	28,773
Ketchikan	16,347
Metlakatla	7,510
Mt. Edgecumbe*	2,785
St. Paul and St. George	4,683
Tanana	2,241
Arizona	
Bylas	10,251
Chinle	37,182
Cibecue	7,871
Dilkon	3,909
Fort Wingate*	2,413
Kayenta	32,502
Leupp	4,187
Many Farms*	4,073
Peach Springs	9,848
Phoenix*	4,324
Santa Rosa	8,053
San Xavier	14,255
Shonto	5,445
Teec Nos Pos	6,250
Toyei	759
Winslow	24,797
California	
Riverside*	7,765
Colorado	
Ignacio	10,550
Towaoc	9,628
Idaho	
Fort Hall	28,087
Lapwai	11,637
Kansas	
Haskell*	10,619
Holton	6,932
Michigan	
Kincheloe	14,346
Minnesota	
White Earth	18,212
Montana	
Lame Deer	28,814
Lodge Grass	9,846
Poplar	31,210
Rocky Boy's	16,662
Wolf Point	14,426
New Mexico	
Canoncito	5,286
Dulce	16,055
Isleta	12,197
Jemez	8,454
Laguna	10,274
Southwestern Poly-Tech Institute*	1,099
Taos	8,097
Tohatchi	12,016
North Dakota	
Ft. Totten	21,021
Ft. Berthold	13,500
Oklahoma	
Anadarko	15,507
Concho*	5,041
Jay	16,001
Hugo	10,749
Broken Bow	10,469
McAlester	11,184
Miami	31,153
Pawhuska	14,094
Pawnee	14,378
Shawnee	31,782
Tishomingo	12,239
Watonga	6,698
Wewoka	26,108
White Eagle	17,335
Oregon	
Chemawa	12,348
Warm Springs	19,859
Yellowhawk	12,786
South Dakota	
Flandreau*	8,704
McLaughlin	10,355
Pierre*	2,441
Wanblee	4,776
Wahpeton*	7,329
Utah	
Ft. Duchesne	11,848
Intermountain*	12,656
Washington	
Colville	17,293
Inchelium	4,317
Lummi	17,092
Neah Bay	10,761
Taholah	9,364
Wellpinit	13,441
Yakima	38,618
Wyoming	
Arapahoe	20,141
Ft. Washakie	27,658
Totals	
Health Centers	79
Visits in 1983	1,049,718

*School Health Center

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Indian Health Service
Administrative Offices

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Headquarters

Indian Health Service
Parklawn Building, Rm. 5A-55
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-1083

Areas

Aberdeen Area Office
Indian Health Service
Federal Building
115 4th Avenue, S.E.
Aberdeen, South Dakota 57401
(605) 225-0250

Alaska Area Native Health Service Office
Indian Health Service
P.O. Box 7-741
Anchorage, Alaska 99510
(907) 279-6661

Albuquerque Area Office
Indian Health Service
Federal Building
500 Gold Avenue, S.W.
Albuquerque, New Mexico 87101
(505) 766-2151

Billings Area Office
Indian Health Service
P.O. Box 2143
2727 Central Avenue
Billings, Montana 59103
(406) 657-6403

Navajo Area Office
Indian Health Service
P.O. Box G
Window Rock, Arizona 86515
(602) 871-5811

Oklahoma City Area Office
Indian Health Service
215 Dean A. McGee Street, N.W.
Oklahoma City, Oklahoma 73102
(405) 231-4796

Phoenix Area Office
Indian Health Service
3738 N. 16th Street, Suite A.
Phoenix, Arizona 85016
(602) 241-2052

Portland Area Office
Indian Health Service
Federal Building, Room 476
1220 S.W. 3rd Avenue
Portland, Oregon 97204
(503) 221-2020

Programs

Bemidji Program Office
Indian Health Service
203 Federal Building
Box 489
Bemidji, Minnesota 56601
(218) 751-7701

California Program Office
Indian Health Service
2999 Fulton Avenue
Sacramento, California 95821
(916) 484-4836

Nashville Program Office
Indian Health Service
Oaks Tower Building, Suite 810
1101 Kermit Drive
Nashville, Tennessee 37217
(615) 251-5104

Tucson Program Office
Indian Health Service
P.O. Box 11340
Tucson, Arizona 85734
(602) 629-5010

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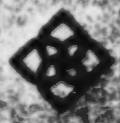

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